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ABSTRACT

The purpose of this fact sheet is to share what is known about the impact of violence and disasters on children and to suggest steps to minimize long-term emotional harm. Trauma is defined to include emotional as well as physical experiences and injuries. It is noted that even secondhand exposure to violence can be traumatic and, therefore, all children and adolescents exposed to violence or disaster, even if only through graphic media reports, should be watched for signs of distress. Loss of trust and fear of the event occurring again are seen in many children and adolescents who have been exposed to traumatic events. After violence or a disaster occurs, the family is the first-line resource for helping. Among the things that parents and other adults can do are explain the episode as well as they are able, encourage the children to express their feelings, let children know that it is normal to feel upset, and allow time for the youngsters to experience and talk about their feelings. The fact sheet concludes with a discussion of post-traumatic stress disorder, its diagnosis and treatment, and what scientists at the NIMH are learning about trauma in children and adolescents. (GCP)

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NIMH
National Institute of Mental Health

Helping Children and Adolescents Cope with Violence and Disasters

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The National Institute of Mental Health has joined with other Federal agencies* to address the issue of reducing school violence and assisting children who have been victims of or witnesses to violent events. Recent nationally reported school shootings such as those that occurred in Bethel, Alaska; Pearl, Mississippi; West Paducah, Kentucky; Jonesboro, Arkansas; Edinboro, Pennsylvania; Springfield, Oregon; and Littleton, Colorado have shocked the country. Many questions are being asked about how these tragedies could have been prevented, how those directly involved can be helped, and how we can avoid such events in the future.

School violence is not a simple issue, however, nor is the aftermath of violence predictable. Research has shown that both adults and children who experience catastrophic events show a wide range of reactions. Some suffer only worries and bad memories that fade with emotional support and the passage of time. Others are more deeply affected and experience long-term problems. Research on post-traumatic stress disorder (PTSD) shows that some soldiers, survivors of torture and other violence, and survivors of natural catastrophes suffer long-term effects from their experiences. Children who have witnessed violence in their families, schools, or communities are also vulnerable to serious long-term problems. Their emotional reactions,

An NIMH Snapshot

The National Institute of Mental Health (NIMH) is one of 25 components of the National Institutes of Health (NIH), the Government's principal biomedical and behavioral research agency. NIH is part of the U.S. Department of Health and Human Services.

The fiscal year 1999 NIMH budget is $855 million.

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How Does the Institute Carry Out Its Mission?

- NIMH supports research on mental disorders, neuroscience, and behavior.
- NIMH collects, analyzes, and disseminates statistical information on the causes, occurrence, and treatment of mental illnesses.
- NIMH is training more than 1,000 scientists to carry out basic and clinical research.
- NIMH communicates information to scientists, the public, the news media, and primary and mental health care providers about mental illnesses, the brain, mental health, and research in these areas.

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* Other Federal agencies involved in addressing the problems of school violence and/or response to disasters:

Center for Mental Health Services (CMHS): The Federal Emergency Management Agency, working with the Center for Mental Health Services' Emergency Services and Disaster Relief Branch (ESDRB), provides funding support for mental health services following a disaster. The Crisis Counseling Assistance and Training Program is implemented at the request of a state or territory when a "Major Disaster" has been declared by the President. Funding for the Crisis Counseling Program (CCP) is not automatic. Funding is provided if the need is beyond the means of state and local providers. Legislative authority is based on the Robert T. Stafford Disaster Assistance Act, Section 416 (Public Law 100-707). There are three components to the CCP program: Immediate Services, Regular Services, and Training and Preparedness. The 60-day Immediate Services Program (ISP) provides services from the date of the incident. The Regular Services Program (RSP) follows the ISP when there is a proven need and provides services for up to 9 months. A week-long training program is completed each year for state mental health authorities to assist in planning for mental health response to disasters. For more information about the CCP program, call the Emergency Services and Disaster Relief Branch, CMHS, at (301) 443-4735.

Department of Education

Department of Justice

Department of Veterans Affairs

Federal Emergency Management Agency

including fear, depression, withdrawal or anger, can occur immediately or some time after the tragic event. Youngsters who have experienced a catastrophic event often need support from parents and teachers to avoid long-term emotional harm. Most will recover in a short time, but the minority who develop PTSD or other persistent problems need treatment.

The school shootings caught the Nation's attention, but these events are only a small fraction of the many tragic episodes that affect children's lives. Each year many children and adolescents sustain injuries from violence, lose friends or family members, or are adversely affected by witnessing a violent or catastrophic event. Each situation is unique, whether it centers upon a plane crash where many people are killed; automobile accidents involving friends or family members; or natural disasters such as Hurricane Andrew, where deaths occur and homes are lost – but these events have similarities as well, and cause similar reactions in children. Helping young people avoid or overcome emotional problems in the wake of violence or disaster is one of the most important challenges a parent, teacher, or mental health professional can face. The purpose of this fact sheet is to tell what is known about the impact of violence and disasters on children and suggest steps to minimize long-term emotional harm.

Trauma—What Is It?

Trauma includes emotional as well as physical experiences and injuries. Emotional injury is essentially a normal response to an extreme event. It involves the creation of emotional memories, which arise through a long-lasting effect on structures deep within the brain. The more direct the exposure to the traumatic event, the higher the risk for emotional harm. Thus in a school shooting, the student who is injured probably will be most severely affected emotionally. And the student who sees a classmate shot, even killed, probably will be more emotionally affected than the student who was in another part of the school when the violence occurred. But even second-hand exposure to violence can be traumatic. For this reason, all children and adolescents exposed to violence or a disaster, even if only through graphic media reports, should be watched for signs of emotional distress.

How Children and Adolescents React to Trauma

Reactions to trauma may appear immediately after the traumatic event or days and even weeks later. Loss of trust in adults and fear of the event occurring again are responses seen in many children and adolescents who have been exposed to traumatic events. Other reactions vary according to age:

For children 5 years of age and younger, typical reactions include a fear of being separated from the parent, crying, whimpering, screaming, immobility and/or aimless motion, trembling, frightened facial expressions and excessive clinging. Parents may also notice children returning to behaviors exhibited at earlier ages (these are called regressive behaviors), such as thumb-sucking, bedwetting, and fear of darkness. Children in this age bracket tend to be strongly affected by the parents' reactions to the traumatic event.

Children 6 to 11 years old may show extreme withdrawal, disruptive behavior, and/or inability to pay attention. Regressive behaviors, nightmares, sleep problems, irrational fears, irritability, refusal to attend school, outbursts of anger and

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fighting are also common in traumatized children of this age. Also the child may complain of stomach aches or other bodily symptoms that have no medical basis. School work often suffers. Depression, anxiety, feelings of guilt and emotional numbing are often present as well.

Adolescents 12 to 17 years old are likely to exhibit responses similar to those of adults, including flashbacks, nightmares, emotional numbing, avoidance of any reminders of the traumatic event, depression, substance abuse, problems with peers, and anti-social behavior. Also common are withdrawal and isolation, physical complaints, suicidal ideation, school avoidance, academic decline, sleep disturbances, and confusion. The adolescent may feel extreme guilt over his or her failure to prevent injury or loss of life, and may harbor revenge fantasies that interfere with recovery from the trauma.

Some youngsters are more vulnerable to trauma than others, for reasons scientists don't fully understand. It has been shown that the impact of a traumatic event is likely to be greatest in the child or adolescent who previously has been the victim of child abuse or some other form of trauma, or who already had a mental health problem. And the youngster who lacks family support is more at risk for a poor recovery.

Helping the Child or Adolescent Trauma Victim

Early intervention to help children and adolescents who have suffered trauma from violence or a disaster is critical. Parents, teachers and mental health professionals can do a great deal to help these youngsters recover. Help should begin at the scene of the traumatic event.

According to the National Center for Post-Traumatic Stress Disorder of the Department of Veterans Affairs, workers in charge of a disaster scene should:

- Find ways to protect children from further harm and from further exposure to traumatic stimuli. If possible, create a safe haven for them. Protect children from onlookers and the media covering the story.
- When possible, direct children who are able to walk away from the site of violence or destruction, away from severely injured survivors, and away from continuing danger. Kind but firm direction is needed.
- Identify children in acute distress and stay with them until initial stabilization occurs. Acute distress includes panic (marked by trembling, agitation, rambling speech, becoming mute, or erratic behavior) and intense grief (signs include loud crying, rage, or immobility).
- Use a supportive and compassionate verbal or non-verbal exchange (such as a hug, if appropriate) with the child to help him or her feel safe. However brief the exchange, or however temporary, such reassurances are important to children.

After violence or a disaster occurs, the family is the first-line resource for helping. Among the things that parents and other caring adults can do are:

- Explain the episode of violence or disaster as well as you are able.
- Encourage the children to express their feelings and listen without passing judgment. Help younger children learn to use words that express their feelings. However, do not force discussion of the traumatic event.
- Let children and adolescents know that it is normal to feel upset after something bad happens.
- Allow time for the youngsters to experience and talk about their feelings. At

home, however, a return to routine can be reassuring to the child.

- If your children are fearful, reassure them that you love them and will take care of them. Stay together as a family as much as possible.
- If behavior at bedtime is a problem, give the child extra time and reassurance. Let him or her sleep with a light on or in your room for a limited time if necessary.
- Reassure children and adolescents that the traumatic event was not their fault.
- Do not criticize regressive behavior or shame the child with words like "babyish."
- Allow children to cry or be sad. Don't expect them to be brave or tough.
- Encourage children and adolescents to feel in control. Let them make some decisions about meals, what to wear, etc.
- Take care of yourself so you can take care of the children.

When violence or disaster affects a whole school or community, teachers and school administrators can play a major role in the healing process. Some of the things educators can do are:

- If possible, give yourself a bit of time to come to terms with the event before you attempt to reassure the children. This may not be possible in the case of a violent episode that occurs at school, but sometimes in a natural disaster there will be several days before schools reopen and teachers can take the time to prepare themselves emotionally.
- Don't try to rush back to ordinary school routines too soon. Give the children or adolescents time to talk over the traumatic event and express their feelings about it.
- Respect the preferences of children who do not want to participate in class discussions about the traumatic event. Do not force discussion or repeatedly bring up the catastrophic event; doing so may re-traumatize children.
- Hold in-school sessions with entire classes, with smaller groups of students, or with individual students. These sessions can be very useful in letting students know that their fears and concerns are normal reactions. Many counties and school districts have teams that will go into schools to hold such sessions after a disaster or episode of violence.
- Offer art and play therapy for children in primary school.
- Be sensitive to cultural differences among the children. In some cultures, for example, it is not acceptable to express negative emotions. Also, the child who is reluctant to make eye contact with a teacher may not be depressed, but may simply be exhibiting behavior appropriate to his or her culture.
- Encourage children to develop coping and problem-solving skills and age-appropriate methods for managing anxiety.
- Hold meetings for parents to discuss the traumatic event, their children's response to it, and how they and you can help. Involve mental health professionals in these meetings if possible.

Most children and adolescents, if given support such as that described above, will recover almost completely from the anxiety caused by a traumatic experience within a few weeks. However, some children and adolescents will need more help over a longer period of time in order to heal. Grief over the loss of a loved one, teacher, friend, or pet may take months to resolve, and may be reawakened by a strong reminder such as media reports or the anniversary of the death.

In the immediate aftermath of a traumatic event, and in the weeks following, it is important to identify the youngsters

who are in need of more intensive support and therapy because of profound grief or some other extreme emotion. Children who show avoidance and numbing may need the help of a mental health professional, while more common reactions such as re-experiencing the event and hyperarousal (including sleep disturbances and a tendency to be easily startled) may respond to help from parents and teachers.

Post-Traumatic Stress Disorder

As stated earlier, some children and adolescents will have prolonged problems after a traumatic event. These potentially chronic conditions include depression and prolonged grief. Another serious and potentially long-lasting problem is post-traumatic stress disorder (PTSD). This condition is diagnosed when the following symptoms have been present for longer than one month:

- Re-experiencing the event through play or in trauma-specific nightmares or flashbacks, or distress over events that resemble or symbolize the trauma.
- Routine avoidance of reminders of the event or a general lack of responsiveness (e.g., diminished interests or a sense of having a foreshortened future).
- Increased sleep disturbances, irritability, poor concentration, startle reaction and regression.

Rates of PTSD identified in child and adult survivors of violence and disasters vary widely. For example, estimates range from 2% after a natural disaster (tornado), 28% after an episode of terrorism (mass shooting), and 29% after a plane crash. The disorder may arise weeks or months after the traumatic event. PTSD may resolve without treatment, but some form of therapy by a mental health professional is often required in order for healing to occur. Fortunately, it is more common for a traumatized child or adolescent to have some of the symptoms of PTSD than to develop the full-blown disorder. People differ in their vulnerability to PTSD, and the source of this difference is not known in its entirety.

Research has shown that PTSD clearly alters a number of fundamental brain mechanisms. Because of this, abnormalities have been detected in brain chemicals that affect coping behavior, learning, and memory among people with the disorder. Recent brain imaging studies have detected altered metabolism and blood flow as well as anatomical changes in people with PTSD. Further information on PTSD and research concerning it may be found in the NIMH fact sheet, "Facts About Post-Traumatic Stress Disorder," which is posted on the NIMH Web site (www.nimh.nih.gov) or available by mail from the address noted on the accompanying resources list.

Treatment of PTSD

People with PTSD are treated with specialized forms of psychotherapy and sometimes with medications or a combination of the two. One of the forms of psychotherapy shown to be effective is cognitive-behavioral therapy, or CBT. In CBT, the patient is taught methods of overcoming anxiety or depression and modifying undesirable behaviors such as avoidance. The therapist helps the patient examine and re-evaluate beliefs that are interfering with healing, such as the belief that the traumatic event will happen again. Children who undergo CBT are taught to avoid "catastrophizing." For example, they are reassured that dark clouds do not necessarily mean another hurricane, that the fact that someone is angry doesn't necessarily mean that another shooting is imminent, etc. Play therapy and art therapy

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also can help younger children to remember the traumatic event safely and express their feelings about it. Other forms of psychotherapy that have been found to help persons with PTSD include group and exposure therapy. A reasonable period of time for treatment of PTSD is 6 to 12 weeks with occasional follow-up sessions, but treatment may be longer depending on a patient's particular circumstances. Research has shown that support from family and friends can be an important part of recovery and that involving people in group discussion very soon after a catastrophic event may reduce some of the symptoms of PTSD.

There has been a good deal of research on the use of medications for adults with PTSD, including research on the formation of emotionally charged memories and medications that may help to block the development of symptoms. Medications appear to be useful in reducing overwhelming symptoms of arousal (such as sleep disturbances and an exaggerated startle reflex), intrusive thoughts, and avoidance; reducing accompanying conditions such as depression and panic; and improving impulse control and related behavioral problems. Research is just beginning on the use of medications to treat PTSD in children and adolescents. There is preliminary evidence that psychotherapy focused on trauma and grief, in combination with selected medications, can be effective in alleviating PTSD symptoms and accompanying depression. More medicatión treatment research is needed to increase our knowledge of how best to treat children who have PTSD.

A mental health professional with special expertise in the area of child and adolescent trauma is the best person to help a youngster with PTSD. Organizations on the accompanying resource list may help you to find such a specialist in your geographical area.

What Are Scientists Learning About Trauma in Children and Adolescents?

The National Institute of Mental Health (NIMH), a part of the Federal Government's National Institutes of Health, supports research on the brain and a wide range of mental disorders, including PTSD and related conditions. The Department of Veterans Affairs also conducts research in this area with adults and their family members.

Recent research findings include:

- Some studies show that counseling children very soon after a catastrophic event may reduce some of the symptoms of PTSD. A study of 12,000 schoolchildren who lived through a hurricane in Hawaii found that those who got counseling early on were doing much better two years later than those who did not.
- Parents' responses to a violent event or disaster strongly influence their children's ability to recover. This is particularly true for mothers of young children. If the mother is depressed or highly anxious, she may need to get emotional support or counseling in order to be able to help her child.
- Community violence can have a profound effect on teachers as well as students. One study of Head Start teachers who lived through the 1992 Los Angeles riots showed that 7% had severe post-traumatic stress symptoms, and 29% had moderate symptoms. Children also were acutely affected by the violence and anxiety around them. They were more aggressive and noisy and less likely to be obedient or get along with each other.

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- PTSD is often accompanied by depression. In a group of teenage religious school students who survived a terrorist shooting in Brooklyn, New York, 4 of the 11 survivors interviewed had both PTSD and depression. In another study, this one involving adults, depression occurred in 44.5% of PTSD patients at 1 month after the traumatic event and in 43.2% at 4 months. Depression must be treated along with PTSD in these instances, and early treatment is best.
- Either being exposed to violence within the home for an extended period of time or exposure to a one-time event like an attack by a dog can cause PTSD in a child. Some scientists believe that younger children are more likely to develop the disorder than older ones.
- Inner-city children experience the greatest exposure to violence. A study of young adolescent boys from inner-city Chicago showed that 68% had seen someone beaten up and 22.5% had seen someone shot or killed. Youngsters who had been exposed to community violence were more likely to exhibit aggressive behavior or depression within the following year.

NIMH-supported scientists are continuing to conduct research into the impact of violence and disaster on children and adolescents. For example, one study will follow 6,000 Chicago children from 80 different neighborhoods over a period of several years. It will examine the emotional, social and academic effects of exposure to violence. In some of the children, the researchers will look at the role of stress hormones in a child or adolescent's response to traumatic experiences. Another study will deal specifically with the victims of school violence, attempting to determine what places children at risk for victimization at school and what factors protect them. It is particularly important to conduct research to discover which individual, family, school and community interventions work best for children and adolescents exposed to violence or disaster, and to find out whether it is possible for an ill-designed intervention to set the youngsters back by keeping the trauma alive in their minds. Through research, NIMH hopes to gain knowledge to lessen the suffering that violence and disasters impose on children and adolescents and their families.

The general public can obtain publications about PTSD and other anxiety disorders by calling NIMH's toll-free information service, 1-88-88-ANXIETY or calling NIMH public inquiries at (301) 443-4513. Information is also available online from NIMH's Web site: http://www.nimh.nih.gov/anxiety. This site is hot-linked to the Web site for the National Center for Post-Traumatic Stress Disorder of the Department of Veterans Affairs at http://www.dartmouth.edu/dms/ptsd. The accompanying resource list indicates agencies or organizations that may have additional information about helping children and adolescents cope with violence and disasters. ***Reporters:*** For more information about post-traumatic stress disorder and other anxiety disorders, contact the NIMH press office at (301) 443-4536.

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Violence/Disasters/PTSD Resource List

National Institute of Mental Health (NIMH)
Office of Communications and Public Liaison
Information Resources and Inquiries Branch
6001 Executive Blvd., Room 8184, MSC 9663
Bethesda, MD 20892-9663
Phone: (301) 443-4513
FAX: (301) 443-4279
Mental Health FAX 4U: 301-443-5158
E-mail: nimhinfo@nih.gov
NIMH home page address:
www.nimh.nih.gov

Center for Mental Health Services (CMHS)
Emergency Services and Disaster Relief Branch
5600 Fishers Lane, Room 16C-26
Rockville, MD 20857
(301) 443-4735
Internet: http://www.samhsa.gov/cmhs/cmhs.htm

U.S. Department of Education
600 Independence Avenue, SW
Washington, DC 20202-0498
Phone: 1-800-USA-LEARN
Internet: http://www.ed.gov

U.S. Department of Justice
950 Pennsylvania Avenue, NW
Washington, DC 20530-0001
Internet: http://www.usdoj.gov

Federal Emergency Management Agency
(Information for children and adolescents)
Internet: http://www.fema.gov/kids

International Society for Traumatic Stress Studies (ISTSS)
60 Revere Drive, Suite 500
Northbrook, IL 60062
Phone: (847) 480-9028
Internet: http://www.istss.com

National Center for PTSD
215 N. Main Street
White River Junction, VT 05009
Phone: (802) 296-5132
Internet: http://www.dartmouth.edu/dms/ptsd

National Organization for Victim Assistance (NOVA)
1757 Park Rd., NW
Washington, DC 20010
Phone: 1 (800) 879-6682
Internet: http://www.try-nova.org

National Victim Center
2111 Wilson Blvd., Suite 300
Arlington, VA 22201
Phone: (703) 276-2880
Internet: http://www.nvc.org

Office for Victims of Crime Resource Center
National Criminal Justice Reference Service
P.O. Box 6000
Rockville, MD 20850
Phone: 1 (800) 627-6872
Internet: http://www.ncjrs.aspensys.com

American Psychiatric Association
1400 K Street, NW
Washington, DC 20005
Answer Center: (202) 682-6000
Internet: http://www.psych.org

American Psychological Association
750 First Street, NE
Washington, DC 20002
Phone: (202) 336-5500
Internet: http://www.apa.org

American Academy of Child and Adolescent Psychiatry
3615 Wisconsin Avenue, NW
Washington, DC 20016-3007
Phone: (202) 966-7300
Internet: http://www.aacap.org

Anxiety Disorders Association of America (ADAA)
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Fax: (301) 231-7392
Internet: http://www.adaa.org

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